Library

BOROUGH of CHARD

HEALTH
A 18 AUG 56
C.R. 17

Annual Report

OF THE

Medical Officer of Health

for the Year ended 31st December, 1955

MINISTRY OF HEALTH
LIBRARY

PUBLIC HEALTH OFFICERS:

Medical Officer of Health:
A. M. McCALL, M.R.C.S., L.R.C.P., D.P.H.

Deputy Medical Officer of Health:	Sanitary Inspector:
P. P. FOX, M.B., Ch.B., D.P.H.	P. H. WEBB, M.I.M. & C.E.

PUBLIC HEALTH COMMITTEE.

R. W. M. Hocken (Chairman)
M. H. Collins
S. Adcock
Mrs. M. A. Bryer
J. E. Case
W. A. H. Evans
L. Fisher
E. E. Huish

HOUSING COMMITTEE.

S. Adcock (Chairman)
S. C. Major
E. T. Phelps
Mrs. M. A. Bryer
L. Fisher
C. J. Rose

HEALTH VISITORS

E. G. Major, S.R.N., S.C.M., H.V.
G. E. Slocombe, S.R.N., S.C.M., H.V.
J. D. Ralston, S.R.N., S.C.M., H.V.
H. E. Parker, S.R.N., S.C.M., H.V.
Mrs. J. M. Pitt, S.R.N., S.C.M., H.V.

YOUNG AND SON (PRINTERS), LTD., CHARD

Annual Report of the
MEDICAL OFFICER OF HEALTH

To the Mayor, Aldermen and Councillors of the Borough of Chard.

Mr. Mayor and Councillors,

I beg to submit my Annual Report for the year 1955.

There was an outbreak of measles in the early part of the year, otherwise few cases of infectious disease were notified.

As I forecast last year, the provision of a clinic building in the town by the County Council has increased the services they are able to provide for our residents and these have been noted in the text.

I hope that the report on the survey of colour vision among school children will be of interest to parents.

There is still a need for more active prevention of tuberculosis and I have given details of the latest position in the use of B.C.G. vaccine.

I wish to acknowledge the courtesy shown to me by the Public Health Committee and the Council during the year.

I am, Mr. Mayor and Councillors,

Your obedient Servant,

A. M. McCALL,
Medical Officer of Health.

SECTION A.

Statistics and Social Conditions of the Area

Population.

The Registrar General gives the estimated mid-year population for 1955 as 5,390, which is about the same as the previous year. Appendix A Table I gives the general statistical details of the town.

Birth Rate.

The Birth Rate for the year was 12.9 per 1,000, which is slightly below that of the previous year. It compares unfavourably with 15 per 1,000, which is the figure for England and Wales as a whole. Details are shown in Appendix A Table 2.

Death Rate.

The Death rate was 10.74 per 1,000 which is a decrease on last year. When the Comparability Factor of 0.88 is taken into account it gives a figure of 9.45 per 1,000, which is well below that of 11.7 per 1,000 for England and Wales. Causes of death are shown in Appendix A Table 3. Diseases of the heart and circulation were again at the top of the list, having caused twenty-four out of a total of fifty-eight deaths. The need for research into these two main causes of death is obvious. Cancer was the cause of ten deaths, only one of these being a case of lung cancer.

Infant Mortality.

There were two cases of infant death, both were premature children who only survived a few hours. There were also five still births.

Maternal Mortality.

I am pleased to be able to report that yet another year has passed without a maternal death.

Social Conditions.

There was little change in the social conditions of the town and once again unemployment was negligible.

SECTION B.

General Provision of Health Services in the Area.

It is my constant aim to increase the medical services of the town, whether they be administered by the Local Health Authority or by the Regional Hospital Board, and during 1955 I am pleased to be able to report that two new clinics were commenced in the newly-constructed County Council Clinic building. These were an ante-natal clinic and an orthopaedic clinic and they will be referred to later in the text.

The new clinic, which is situated in the High Street, is a prefabricated building and is erected on a site made available by the Borough Council and situated immediately below Durstons. It contains a waiting hall and on the left hand side a self-contained dental clinic with treatment and recovery rooms and dental office, and on the right is a medical consulting room and separate nurses' weighing room, etc. In addition a reception office and adequate lavatory accommodation is provided and there is a pram shelter at the rear. The building is well furnished and adequately heated and lighted and is a very great asset.

Care of Mothers and Young Children.

Infant Welfare Clinics.

These clinics were held twice each month and Dr. Elliott was present on all occasions. There was an improvement in the numbers attending this clinic, no doubt due to the greatly improved surroundings in which it is now held.

The correct function of a clinic of this type is to keep a child in perfect health from the date of its birth until it has reached school age and with this aim in mind the clinic functions as follows:—

On the first attendance of the mother and child full details of the child's birth are recorded, the child is then stripped and weighed and taken in to see the doctor, who thoroughly examines the baby. The mother is advised on any abnormality which may be detected, and a course of action outlined. Subsequently, the child is stripped and weighed at each visit, and the mother is able to receive advice from one of the health visitors who is in attendance for that particular purpose. If either the health visitor or the nurse weighing the children is unhappy about the condition of any infant, it is immediately seen by the doctor. If treatment or hospital appointments are needed these are made through the child's private practitioner. Immunisation against diphtheria and whooping cough is offered and the value of this procedure is explained.

This routine work has proved to be of great value. An abnormality is detected at the very earliest moment when the chance of correction is very much better than when it is an established disease. The misapprehension of some parents that the clinic is a ready method of checking the diagnosis of their own doctor, is very strongly discouraged, and no advice or treatment is suggested whilst a child is actively attending its own general practitioner. It is also stressed to the parent that any suggested treatment can only be commenced with the full approval of the private doctor, and in this way the Health Department endeavours to foster a strong link with the general practitioners' service.

Whilst the clinic is in session, certain proprietary foods and vitamin preparations may be purchased at special rates. National welfare foods are still sold in the Council Offices and it might lead to less confusion if this was done from the clinic building itself as is the case in some towns.

Ante-Natal Clinics.

An ante-natal clinic has been started once a month and Dr. Elliott attends these sessions for the purpose of taking blood samples for submission to the laboratory. The samples are examined as a routine for Wasserman and Khan re-actions, haemoglobin estimation and the Rhesus factor. The examination of the blood of expectant mothers is now a routine procedure in the town and well supported by the local doctors. In addition to this clinic the private practitioners and nurses carry out ante-natal examinations of the patient either in their surgeries or in the patient's own home.

Domiciliary Midwifery.

The district nurses continued to attend expectant and nursing mothers in their homes with the private practitioner supervising the case.

Health Visiting.

The district nurses carry out general health visiting duties and Mrs. Pitt is the tuberculosis health visitor.

The primary function of a health visitor is to visit the home of the people and I am quite confident that at present this work is being done in a very efficient manner. This is particularly true in respect of the following up of children with defects discovered at school medical inspections. None are overlooked, and if parents co-operate they will derive a maximum benefit from this part of the Health Service.

Home Nursing.

In addition to their many other duties, the district nurses visit people's homes to carry out a very large number of duties. These may include dressing wounds, giving injections, bathing patients, and many other similar medical duties too numerous to list. A great deal of this work is concerned with the older members of the community, and we have every reason to be thankful for the kindly manner in which our nurses have been working during the past year.

Immunisation.

During the year the County Council, as Local Health Authority, in co-operation with the Borough Council, took every opportunity to stress the need for immunisation against diphtheria. An intensive publicity drive was organised in November during which time posters were displayed on the Council's notice boards and also in the local Press. Immunisations were mainly carried out by Dr. Elliott at the Infant Welfare Clinic and in addition there is a considerable amount of work done by the general practitioners of the town.

There is a growing demand for combined immunisation against whooping cough and diphtheria. This is given in three injections at monthly intervals, starting at the fourth month, so that the course is completed before teething commences in earnest. If, however, parents request immunisation against diphtheria only, then this is given at a slightly later age and necessitates two injections. All children require a further booster dose against diphtheria at the age of five years, so this is given when they commence school.

A total number of forty-three primary immunisations were given during the year.

Vaccination.

Thirty-five primary vaccinations and five re-vaccinations were done in 1955. This is still not a satisfactory number. The reaction to vaccination in infancy is very mild indeed and all boys who later do National Service must be either vaccinated or re-vaccinated. A primary vaccination in adult life can produce a much more severe constitutional upset than the mild re-action resulting from a similar procedure in infancy.

This is only one minor aspect; the real need is to protect the population against small pox which has ravaged this country in the past and as Macaulay has described it "is the most terrible of all ministers of death." I cannot stress too often that in these days of rapid air travel from the East and the increasing number of unvaccinated persons in the population, the danger of an outbreak increases.

Home Help Service.

The Home Help Service organised by the County Council was available in the town throughout the year. It is of very great value and the County Council are spending more each year on this Service.

School Medical Service.

I carry out school medical inspections in all the County schools in the town and details of these can be found in Appendix B Table 2. I continued to give a full examination to all children on entry to school life, on transfer from primary to secondary education, and in the last six months before leaving school. In addition, I examined all children with defects and all cases specially referred to me by the teachers or at the request of parents.

Colour Vision.

During the routine medical inspection of school children, I carried out an investigation into the proportion of children who are Colour Blind. There seems to be a good deal of confusion in parents' minds about the subject, so I feel it will be useful to discuss some aspects of the condition.

To start with, the term Colour Blindness is a misnomer and a far better term is "defective colour vision," and it is the one which I propose to use.

We have as yet no definite information about the cause of defective colour vision. The outstanding characteristic of all persons with the condition is that the total number of colours which they can recognise as distinct from one another is significantly smaller than the number which the normal observer can distinguish under the same conditions.

A person with defective colour vision is a person with a deficiency and not merely a different form of vision. The most striking deficiency is usually revealed when the attempt to distinguish red from yellow or yellow from green is made, with the absence of any brightness difference. Other colours which tend to be confused are blue, green, grey and purple. On the other hand, the defect does not normally lead to much difficulty in distinguishing green from blue green, blue green from blue, yellow from grey or grey from blue.

One point which is extremely important should now be noted. A child in the nursery begins to recognise differences between colours and is taught that a brick is red, a banana yellow, an orange is orange, grass is green, etc., until eventually he has a great many objects which help him by association to link up each colour sensation with its appropriate name. Because he has been taught that green is the colour which grass possesses the person with defective colour vision when asked the colour of grass, will naturally reverse the process and reply "green" whatever the quality of his visual sensation. Greens and yellows are lighter than browns and reds and this may help him to differentiate one from the other. It is as well that he has the subsidiary aids to help him. He may, it is true, lose something of the beauties of nature through his reduced range of colours, but since he will be quite unaware of the nature of his loss, it is unlikely to trouble him overmuch.

The type and number of mistakes a colour defective makes will of course depend on the type and degree of the defect. It will also depend on the conditions under which he is working. Persons with normal colour vision often have difficulty in recognising colours when the lighting is bad or the objects are dirty or small in size. Similarly the number of mistakes made by a colour defective increases under these more difficult conditions. Thus while a person with defective colour vision may succeed in distinguishing between red and green signal lights when close at hand, yet when they are seen as pin points of light in the distance, or through fog or rain, they will be far more liable to error.

In the great majority of cases, defective colour vision is congenital, but some loss of colour sense can be acquired, for example, by excessive smoking. When a father is congenitally colour blind his daughters will be carriers of the defect without themselves being defective, but none of his sons will be either a colour defective or a carrier. When a mother is a carrier, half her sons will, on the average, be colour defectives and half her daughters will be carriers. The defect will, however, become evident in half the daughters of a carrier mother and a defective father. When both parents are affected all daughters will have defective colour vision. It follows that the number of women who have defective colour vision is very much smaller than the number of men. Statistics show that the percentage of colour defectives in the male population is approximately 8%. In my small survey in Chard Borough it was 10.85% for boys and 3.9 for girls. Of 129 boys examined 14 were defective and of 103 girls 4 were defective.

Information about the age at which defective colour vision becomes evident is conflicting. It seems quite certain that those who possess the defect do so from their earliest years. However, some children may fail to describe colours correctly because they are mentally backward or through lack of education and not through any defect in their visual apparatus. The earlier it is possible to find out whether children are suffering from colour vision defects the better it is from the point of view of deciding upon their future careers. There are a number of careers which are completely closed to them if they are suffering from colour vision defects.

The desirability of carrying out school testing of colour vision is generally admitted by all who have investigated the condition. Many industrial firms have also stressed its importance so as to avoid disappointment when seeking future employment.

There are many methods of testing colour vision, but one suitable for use by a School Medical Officer has to be quick, not too complicated and capable of being carried out in an ordinary room. I think that confusion charts such as the Ishihara Charts I used in this survey are probably the most suitable. Testing has usually been done on all children due for a routine medical examination at the age of 10. No difficulty was experienced in dealing with children of that age. Once what was required of them was explained they immediately gave full co-operation. The time taken to test each child was generally about one minute. All children found to have a defect were informed of their defect and retested. In each case a letter was sent to the parent informing them of the presence of the defect and reminding them of its bearing on a future career.

I consider that testing by the method suggested above should become standard throughout the Somerset County school medical service. All those with seriously defective colour vision would be known and the parents informed. I also advocate more stringent pre-vocational tests for all who propose to enter a trade or profession in which normal colour vision is important. This latter test is of course outside the scope of the school medical service.

Minor Ailment Clinic.

I do not hold regular sessions at the clinic for the treatment of minor ailments, but arrange a clinic following a school medical inspection, so that any minor conditions with which I can readily deal, are speedily treated. This, I hope, relieves the pressure on general practitioners in their surgeries and enables them to deal with more serious and urgent matters.

School Dental Service.

The County Council were able to appoint a dental surgeon to the Chard area during

1955 as a direct result of our Council offering him housing accommodation.

I list below the names of the school and the date on which they last received a dental inspection:—

Chard Infants—September, 1953.
Chard Junior—May, 1955.
Chard Secondary Modern — November, 1953.

It will be seen that he was only able to carry out an inspection of one of the schools and spent much of his time in the Rural District around. However, he was available for any emergency treatment, this was carried out at the new clinic.

Orthopaedic Services.

An orthopaedic clinic was commenced in Chard in the clinic building and was well supported by parents who previously had to travel to Taunton. A fully qualified orthopaedic sister is in attendance and she sees all cases at regular intervals between their appointments with the specialist in Taunton. In this way she is able to keep a constant check on progress and refer back any who should see the specialist sooner than was anticipated.

Ophthalmic Services.

At each school medical inspection I examine every child who has any eye defect whatsoever. I check the correction of their glasses and also check up on whether or not they are carrying out the directions issued by the ophthalmic specialist after the last appointment. If glasses are in need of repair or the correction does not satisfy me, I refer the child back to the person who dispensed the glasses and in some instances to the County Occulist who holds a weekly clinic specially for children at Taunton.

Epileptics and Spastics.

Any cases of epilepsy occurring in the area are referred to a specialist at Taunton who is able to carry out electro-encephalogram and other necessary investigations and then advise on the correct course of treatment. A copy of his report is always available to the school medical officer if the patient be of school age. Where it is considered necessary for a schoolchild to attend a special school on account of the disease, it is possible to have them admitted to the Chalfont Colony where the Somerset County Council maintain a certain number of students.

Blind Persons.

There are eighteen registered blind persons in the Borough and four partially sighted. Appendix B Table 3 shows the details of the follow-up of the blind and partially sighted during 1955.

Ambulance Service.

The Somerset County Ambulance Service covers this area during week days. They have now been equipped with radio telephone and this has undoubtedly increased their efficiency and produced a saving in time and personnel. During non-working hours and at week-ends the St. John Ambulance Brigade have continued to give an ambulance service to Chard and district. They are under the direction of District Superintendent E. F. Brooks, as has been the case for some years past. Appendix B Table 4 gives full details of the work done.

National Assistance Act, Section 47.

No statutory action was necessary during year, although old people frequently show a natural reluctance to leave their house, however dismal, and regardless of their ability to look after themselves.

The prevention, or anyhow the control, of degenerative disease is more important than the treatment of the advanced case. Due to the lack of appreciation of these points in the past, the demand for institutional accommodation for old people far exceeds the supply of beds, and the problem must be tackled vigorously by local authorities. The first requirement is the provision of special housing to meet the particular needs of old age.

SECTION C.

Prevalence and Control Over Infectious and Other Diseases.

A summary of the notifications will be found in Appendix C Table 1.

There was a fairly sharp outbreak of measles in the early part of the year but fortunately there were no serious complications. One case of typhus fever was notified but it occurred in a man who had recently returned from West Africa and undoubtedly the disease was contracted before leaving that country. The case of typhoid fever was a schoolchild in attendance at Ilminster. The source of the infection was not discovered and none of her colleagues became infected.

Mass Radiography.

The Unit visited the town in July and a total of 1,609 persons attended for X-Ray. This is slightly below the 1954 figure. No active case of tuberculosis was discovered but three inactive cases were found. We greatly appreciate the regular visits of the Unit and we also would like to thank Colonel F. K. L. Sandbach, the local Territorial Army commander, for his kindness in allowing the Unit to use the Drill Hall during their visit.

B.C.G. Vaccination and Special Housing.

In my recent Annual Reports, I have referred to B.C.G. vaccination of school-children against tuberculosis. In 1949 official permission was given for its use for nurses and medical staff in hospitals and home contacts of active tuberculosis cases. Permission was extended to include school leavers at the end of 1953. Since then some 130 of the local health authorities have prepared and operated schemes for children.

In Somerset the categories of persons at risk are offered B.C.G. but we still await a scheme for school children of leaving age, that is 14 + years. The notification rate and mortality from tuberculosis in Great Britain begin to rise at about the age of 15 years from their low levels in childhood.

The first progress report of the Tuberculosis Vaccines Trials Committee of the Medical Research Council has now been published. The report of an investigation into the prophylactic effect of B.C.G. and of a similar British vole bacillus vaccine on children aged 14 to 15½ years attending secondary modern schools in selected areas. The investigation which involved 56,700 children was well planned, carefully executed and clearly reported. The results are unequivocal. It is estimated that a general vaccination scheme of children of this age should reduce T.B. Morbidity between the ages of 14-17 by about half.

The most striking fact in the report is that no case of miliary tuberculosis or tuberculous meningitis occurred in the vaccinated groups whereas in the unvaccinated group there were three cases of pulmonary T.B. of a miliary type. In the group vaccinated with B.C.G. the annual incidence of clinical T.B. was 0.37 per 1,000 as opposed to 1.94 per 1,000 of unvaccinated and 0.44 per 1,000 given vole bacillus vaccine.

Each vaccine therefore conferred a substantial and similar degree of protection against T.B. over a period of two and a half years in adolescence. The protection conferred by each vaccine was evident soon after it had been given and was still substantial between two and two and a half years after entry into the trial. Supplementary incomplete information up to four years suggests that the protection is maintained for this period. It also appeared that the vaccinated children fared considerably better than those who had been naturally infected, but were without evidence of clinical disease at the time of entry to the trial.

In view of the very favourable results obtained in this trial among adolescents it is unjustifiable and probably impossible to conduct similar trials in other population groups. This means that policy will have to be based on information at present available, and to be made available in future reports on this trial.

It will be thought by many that the time has arrived for vaccination to be made available in this area to all children whose parents request it.

However, although vaccines can make a substantial contribution to prevention, it should not be assumed that efforts to control the disease by other means can be relaxed.

Special Housing.

I am pleased to say that this Council has always given immediate attention to the housing of tuberculosis patients and occasionally the requirements of some cases have demanded housing of a size which to me has appeared to be uneconomic considering the small number in the family involved. Patients are reluctant to go into hospital for a long stay and modern drugs have greatly eased the treatment of patients at home so there is a tendency towards domiciliary treatment of tuberculosis. Hence this demand for special housing will, if anything, increase. I think the Council might well consider the adaption of some existing three bedroomed houses to give sanatorium-like conditions. A bedroom on the first floor could be altered and windows provided on both front and back walls, the window on the back wall being the length of the whole wall and capable of being folded back. The tenants of these houses should be selected by the Chest Physician and Medical Officer of Health and as soon as the case has received the benefit possible from the special bedroom they should be transferred to the conventional type house. Not only would the patient make a more rapid recovery, but the demand for hospital beds would also decrease. This would be a practical way in which the Council could assist to combat the nation-wide shortage of nurses and in addition offer the tuberculosis patient a welcome alternative to prolonged hospitalization.

SECTION D.

Environmental Health Services.

A. Sanitary Circumstances.

Climatic Conditions.

It was a reasonably dry year with prolonged periods of sunny weather during the Summer. However, in the early months there was some severe weather which included heavy falls of snow as late as May. Fortunately, there was no very cold weather in the latter months.

Water Supply.

The quality of the water was satisfactory throughout the year but owing to the dry Summer there was a severe shortage from July to December and the Council continued their search for a second supply to augment the existing source and also concluded an agreement with the Rural District Council for a supply to tide them over the present difficulties.

Drainage and Sewage.

The town's sewage disposal works continued to be most satisfactory. The effluent was of a high standard, as good as anywhere in Somerset. No extensions to the system were made during the year but the provision of a sewage system for the Holbear district was considered.

On Easter Saturday the ignorant action of one of the employees of an industrial concern in the town led to the discharge of a highly poisonous effluent into the Forton stream, and a large number of fish died. The Council were of the opinion that no one would intentionally pollute a sporting river and it was therefore necessary to prevent such an event occurring again. The Mayor called a meeting in the Town Hall to which were invited representatives of firms, representatives of the River Boards and representatives of the fishing interests. A frank discussion took place and all agreed to co-operate in preventing a further similar occurrence. At the meeting the following resolutions were adopted :—

(a) That all firms in the area be asked to supply details of their drains, processes and use of chemicals, etc., and the volume of effluent they discharge, and

(b) On receipt of such information a sub-committee, comprising representatives of the Somerset & Devon River Boards, the Medical Officer of Health and Sanitary Inspectors of Chard Borough and Rural District Councils, meet to discuss what improvements are necessary and what steps can be taken to prevent further pollution.

Subsequently the Council accepted the recommendations of the sub-committee and all firms were asked to provide neutralising tanks so that the solutions can be dealt with before discharge to the sewerage system and also inspection chambers where samples of the effluent leaving the factories can be readily obtained.

I think this was an excellent practical example of the Council's awareness of the need to prevent pollution of our rivers by discussion rather than litigation.

Public Cleansing and Refuse Collection.

This is done by direct labour, collection being once weekly. In addition collections are made by request for the removal of trade refuse.

The roads have been kept in very good condition by the Council's staff.

Rodent Destruction.

The rodent operator continued to carry out inspections and rodent treatment where necessary in the town. No heavy infestations were detected.

Camping Sites.

There are two licensed sites in the town where the maximum number of caravans allowed is eight per acre. The estimated number of campers resident during the year was twenty-four caravans. In order to ensure that permanent residents were living in conditions which were not detrimental to their health, the Council have laid down strict rules concerning sites. These demand that the type of caravan used shall be of the " all-weather " variety and incorporate proper cooking and heating apparatus and also be properly insulated. They also demand adequate sanitary arrangements and a satisfactory method of refuse disposal.

Swimming Bath.

There is one privately owned swimming bath in the town where purification is by hand chlorination. Samples of the water are submitted for examination from time to time.

B—Factories Act.

Details will be found in Appendix D Table 2.

There is still no information from the Ministry of Health about the possible formation of an industrial medical service: The committee considering this matter is still sitting.

C—Housing.

Appendix D Table 3 gives a very detailed survey of the present position of housing in the town. The Survey Sub-committee of the Public Health Committee continued their inspection of the Borough and on completion of their work details of their proposals for the next fifteen years were forwarded to the Ministry of Housing and were acceptable to them. They provide for the demolition and clearance of a certain number of houses each five-year period until all those considered to be unfit have been replaced by housing of a satisfactory standard.

D—Inspection and Supervision of Food.

Milk.

There are two registered distributors and eight registered dairy premises in the Borough. In addition three supplementary licences were issued to distributors whose premises were outside the area.

Ice Cream.

There is one manufacturer and retailer in the town and sixteen premises are registered for the sale of pre-packed products. Samples were taken from time to time and all conformed to the required standard.

Meat.

There are two licensed slaughter houses in the town and Appendix D Table 4 gives a very detailed account of the number of carcases inspected.

Clean Food Campaign.

The Council continued to publicise the necessity for the careful handling of food and for strict hygiene in catering establishments. No formal action was necessary under Section of the Food and Drugs Act, 1938.

APPENDIX A—TABLE 1

Registrar General's estimate of population mid 1955	5,390
Area	1,030 acres
Number of inhabited houses at the end of 1955 according to the Rate Book	1,767
Rateable Value	£35,367
Sum represented by a penny rate	£135

APPENDIX A—TABLE 2

BIRTH RATE: 12.9 per 1,000. Comparability Factor 1.00.

		M	F
Live Births:	Total	42	29
	Legitimate	42	28
	Illegitimate	—	1
Still Births:	Total	2	3
	Legitimate	2	3
	Illegitimate	—	—
Deaths of Infants under 1 year:	Total	—	2
	Legitimate	—	2
	Illegitimate	—	—
Deaths of Infants under 4 weeks:	Total	—	2
	Legitimate	—	2
	Illegitimate	—	—

APPENDIX A—TABLE 3

DEATH RATE: 10.74 per 1,000. Comparability Factor 0.88.

Causes of Death:	Total	M	F
	58	39	19
Heart:			
Coronary Disease	7	6	1
Hypertension	2	—	2
Other heart disease	7	4	3
Circulation:			
Vascular lesions of nervous system	5	4	1
Other circulatory disease	3	3	—
Cancer of:			
Stomach	1	1	—
Breast	1	—	1
Uterus	1	—	1
Lung	1	1	—
Other Sites	6	5	1
Lungs:			
Tuberculosis	1	1	—
Bronchitis	5	4	1
Other respiratory diseases	1	—	—
Diabetes	1	—	1
Motor accidents	1	1	—
Other ill-defined causes	15	9	6

APPENDIX B—TABLE 1

CHARD CHILD WELFARE CENTRE

Statistics for the twelve months ended 31st December, 1955.

1. Number of children who first attended during the year and who at their first attendance were:—	
UNDER ONE YEAR OF AGE	60
2. Number of children who attended during the year and who were born in:—	
(a) 1955	39
(b) 1954	57
(c) 1953-50	70
3. Total attendances during the year made by children who at the date of attendance were:—	
(a) UNDER ONE YEAR OF AGE	453
(b) OVER ONE BUT UNDER TWO YEARS OF AGE	204
(c) OVER TWO BUT UNDER FIVE YEARS OF AGE	225
4. Number of individual mothers who attended during the year	127
5. (a) TOTAL NUMBER OF SESSIONS HELD:—	
(i) With Medical Officer	23
(ii) Other Sessions	—
(b) NUMBER OF CHILDREN EXAMINED BY DOCTOR	110
(c) TOTAL NUMBER OF MEDICAL CONSULTATIONS	240

APPENDIX B—TABLE 2.

Name of School	No. on Roll	No. Inspected	No. Immunised	Date of Inspection	Children having Milk	Children having Dinners
*Chard Infants	—	—	—	—	—	—
Chard Junior	314	157	—	26/28.1.55	82.80%	60.57%
Chard Secondary Modern	350	79	—	8/10.6.55 15/19.12.55	48.57%	30.28%

*This school was inspected at the end of 1954 instead of at the beginning of 1955 owing to a change of Head Teachers.

APPENDIX B—TABLE 3.

FOLLOW UP OF REGISTERED BLIND AND PARTIALLY SIGHTED PERSONS.

	Cause of Disability.			
	Cateract.	Glaucoma.	Retro: Fibro:	Others.
(i) Number of cases registered during the year in respect of which para. 7 (c) of forms B.D.8 recommends:—				
(a) No treatment	—	—	—	1
(b) Treatment (medical or surgical)	—	—	—	—
(ii) Number of cases at (i) (b) above which on follow-up action have received treatment:—	—	—	—	—

APPENDIX B—TABLE 4.

AMBULANCE SERVICE

Mileage during 1955	4,046
Patients conveyed:—	
Emergencies	60
Accident	37
Maternity	32
Total	129

APPENDIX C—TABLE 1

Infections and Other Notifiable Diseases.

Measles	136
Whooping Cough	3
Typhus	1
Typhoid Fever	1
Erysipelas	2

	Analysis of Cases Notified.											
	Under 1yr.	1-2	2-3	3-4	4-5	5-10	10-15	15-20	20-35	35-45	45-65	65+
Measles	2	14	14	13	15	75	2	1				
Whooping Cough...			2	1								
Typhus											1	
Typhoid Fever ...								1				
Erysipelas											1	1

Tuberculosis

Age Group	New Cases Respiratory M	New Cases Respiratory F	New Cases Non-respiratory M	New Cases Non-respiratory F	Deaths Respiratory M	Deaths Respiratory F	Deaths Non-respiratory M	Deaths Non-respiratory F
-1 ...								
1-5 ...								
5-15 ...				1				
15-25 ...								
25-35 ...	1							
35-45 ...	1	1						
45-55 ...	1				1			
55-65 ...		1						
65+ ...								
Total...	3	2	—	1	1	—	—	—

APPENDIX C—TABLE 2

Mass Radiography

Report of Survey at Chard, July, 1955.

		Male	Female	Total
Miniature films	Total	902	707	1609
Large Films	Total Recalled	14	12	26
	Did not attend	—	—	—
	Normal	2	1	3
	Significant	9	6	15
	Under Observation*	3	5	8
Tuberculosis Conditions				
	Active Tuberculosis	—	—	—
	Inactive Tuberculosis	2	1	3
	Under Observation*	—	3	3

(*Included in above total)

Analysis of Tuberculous Cases.

	Under 15	15-24	25-34	35-44	45-59	60+	Total
Active Tuberculosis							
Male							—
Female							—
Total							—
Inactive Tuberculosis							
Male					1	1	2
Female					1	—	1
Total					2	1	3

Non-Tuberculous Conditions

	Male	Female	Total
Abnormality of the Bony Thorax (Congenital)	—	2	2
Acquired Cardio Vascular Lesion	—	1	1
Bronchiectasis	2	—	2
Pleural Thickening	4	—	4
Pulmonary Fibrosis	1	2	3
Total	7	5	12

APPENDIX D—TABLE 1

Water Supply

Piped Supplies—results of samples taken for analysis:

Raw Water				Treated after going into supply			
Bacteriological		Chemical		Bacteriological		Chemical	
Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory
—	—	—	2	24	—	—	—

Water Supplies from public mains:

Direct to Houses		By means of Standpipes	
No. of Dwellinghouses	Population	No. of Dwellinghouses	Population
1,751	5,389	14	49

APPENDIX D—TABLE 2.

Factories Act, 1937

Inspections for the purpose of provisions as to Health (Including Inspections made by the Sanitary Inspector)

Premises	No. on Register	Inspections	Written Notices	Occupiers Prosecuted
(i) Factories in which Sections 1, 2, 3, 4 & 6 are to be enforced by Local Authorities	38	17	2	Nil
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority	25	11	2	Nil
TOTALS	63	28	4	—
Cases in which defects were found		3	3	Nil
Cases in which defects found were remedied			3	Nil

Outwork.

No. of outworkers in August List required by Section 110 99

APPENDIX D—TABLE 3

Housing.

Total Number of permanent dwellings in District	1,767
Total number of permanent dwellings owned by Local Authority	531

Part 1. The total problem (as per Ministry Circular 55/54) :—

(I)	Estimated number of houses unfit for human habitation within the meaning of Section 9 of the Housing Repairs and Rents Act, 1954 and suitable for action under Section 11 or Section 25 of the Housing Act, 1936	111
(II)	Period in years which the Council think necessary for securing the demolition of all the houses in (I)	10 yrs.

Part 2. Orders already made, etc. :—

(III)	Number of houses in (I) in clearance areas and already covered by operative clearance or compulsory purchase orders or owned by the Local Authority	28
(IV)	Number of houses which are already in clearance areas and for which clearance or compulsory purchase orders have been submitted to the Minister but have not as yet become operative	5

Part 3. Action in the first five years :—

(V)	Number of houses which are already in clearance areas and for which clearance or compulsory purchase orders are to be made or which are to be purchased by agreement within the five years ...	14
(VI)	Number of houses which are to be included in clearance areas still to be declared and which within the five years will be owned by the Local Authority or will have been included in a clearance order or a compulsory purchase order submitted to the Minister	62
(VII)	Number of houses under (III), (IV), (V) and (VI) to be patched (if necessary) and retained within the five years under Section 2 of the Housing Repairs and Rents Act, 1954, for temporary accommodation	18
(VIII)	Number of houses under (III), (IV), (V) and (VI) to be demolished in the five years	78
(IX)	Number of houses (including those already comprised in operative demolition orders) to be demolished in the five years as a result of action under Section 11 of the Housing Act, 1936	33

	Houses erected during the year	Houses in course of erection	**Gained** from conversion of large houses or buildings into flats or dwellings	**Lost** from conversion of two or more houses to one
Local Authority	46	15	—	—
Private Enterprise ...	9	4	—	—
Totals	55	19	—	—

Number of Post-War Houses erected from 1st April, 1945, to 31st December, 1955.		Programme for 1956.	
By Local Authority	By Private Enterprise	By Local Authority	By Private Enterprise
366	69	50	

(a) No. of temporary housing units occupied—(i) Prefabs .... —

(ii) Huts. etc. .... —

(b) No. of houses found overcrowded.. 11

(c) No. of houses closed as a result of an undertaking given by the owners or following the issue of Closing Orders .... —

(d) No. of houses demolished during the year 6

(e) No. of houses made fit during year 9

Houses required:—

(i) To abate overcrowding 8

(ii) To overcome unsatisfactory conditions, e.g. two families living in same house but not included in (i) 62

Total number of applicants for Council Houses at the end of the year 203

Improvement Grants made under the Housing Act, 1949-54.

No. of applications and houses dealt with by Local Authority:

	Received		Approved		Rejected	
	Aps.	No. of houses.	Aps.	No. of houses.	Aps.	No. of houses.
31.7.49—31.12.54 ...	10	10	7	7	3	3
During year	16	16	14	14	2	2
Totals	26	26	21	21	5	5

APPENDIX D—TABLE 4.

MEAT.

Slaughter-Houses and Bacon Factories.

	Licensed	Operating
(a) Private Slaughter-Houses	2	2
(b) Bacon Factories	—	—
(d) No. of Slaughter-Houses in use where horses are slaughtered for human consumption	—	—

Carcases and Offal inspected and condemned in whole or in part during year:

	Cattle Excluding Cows	Cows	Calves	Sheep and Lambs	Pigs	Horses
Number killed (if known)						
Number inspected	767		2645	2940	1081	
All diseases except Tuberculosis and Cysticerci:						
Whole carcases condemned	12		8	14	9	
Carcases of which some part or organ was condemned	119		39	244	134	
Percentage of the number inspected affected with disease other than tuberculosis and cysticerci	17.08		1.8	8.7	13.2	
Tuberculosis only:						
Whole carcases condemned	5				3	
Carcases of which some part or organ was condemned	83		2		51	
Percentage of the number inspected affected with tuberculosis	11.4		.07		4.9	
Cysticercosis:						
Carcases of which some part or organ was condemned						
Carcases submitted to treatment by refrigeration						
Generalised and totally condemned ...						
Weight of meat condemned (in lbs.) for:—						
(a) Tuberculosis	5925				738	
(b) Cysticercosis						
(c) Other	5015		395	941	1172	
Total (in lbs.) condemned	10940		395	941	1910	

Calves and pigs slaughtered on Sundays for Smithfield Market not included.